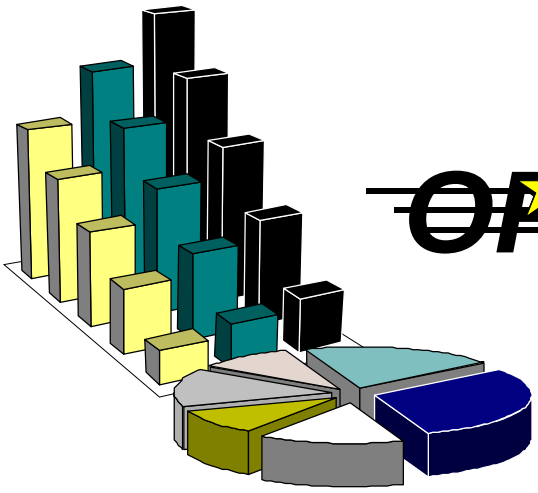

ORD

Office of Research and Demonstrations

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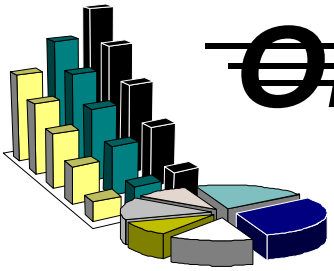


ORD Makes a Difference

As the research arm of the Health Care Financing Administration (HCFA), the Office of Research and Demonstrations (ORD) performs and supports research and demonstration projects to develop and implement new health care payment approaches and financing policies, and to evaluate the impact of HCFA's programs on its beneficiaries, providers, States, and others. The scope of ORD's activities embraces all areas of health care: costs, access, quality, service delivery models, and financing approaches. ORD carries out these responsibilities through both intramural research by its multi-disciplinary staff of economists, physicians, health professionals, social scientists, and health policy analysts, and extramural research sponsored through contracts, grants, interagency agreements, and approvals of Medicare and Medicaid demonstration waivers.

ORD provides leadership and executive direction within HCFA for a wide range of health care financing research and demonstration activities, such as studying vulnerable populations, dealing with alternative health plans, and developing risk adjusters for payments systems . ORD develops, tests, and evaluates new payment methods, coverage policies, and delivery mechanisms in Medicare, Medicaid, and other health care programs.

Over the past three decades, HCFA's Office of Research and Demonstrations (ORD) and its predecessors have had a profound impact on the evolution of the Medicare and Medicaid programs. Through support, development, and testing of innovations in payment, delivery, access and quality, ORD has significantly contributed to major program reforms and improvements. The following list of selected accomplishments outlines just a few of the major contributions of this Office.

PAYMENT

Hospital Payment Reform. With ORD-supported research and demonstrations, Medicare moved from cost reimbursement for hospital care to a prospectively determined per case payment based on diagnosis. ORD's efforts resulted in legislation requiring the use of a DRG system—diagnosis-related groups—as the method of Medicare payment for most hospital care. Implemented in 1983, the DRG system saves billions of Medicare dollars annually and is used today by half of the state Medicaid programs, CHAMPUS, and many insurers, managed care plans, and other countries. It represents the most common form of hospital payment in the U.S. today.

Physician Payment Reform. Through ORD-supported research, a uniform, resource-based fee schedule for paying physicians was developed to replace the Medicare retrospective, charge-based system. This new system was part of physician payment reform legislated in 1989 and implemented in 1992. The concept of using resource-based payment for physician services has spread beyond Medicare to nearly three-quarters of public and private insurers.

Risk Adjustment. Recognizing that risk adjusters are widely needed for payment systems, and monitoring and evaluation purposes, ORD has taken the clear lead in pursuing all viable methods of developing both basic (e.g., based on carve outs for high cost cases) and more complex risk adjusters, such as ambulatory care groups (ACGs) and diagnostic cost groups (DCGs), which use diagnoses from a prior year to predict program costs in a subsequent year. ORD also is exploring the development of other risk adjustment mechanisms, including ACG- and DCG-hybrids, and adjusters for such various populations as the under-65 group and the disabled.

Managed Care Payment Reform. Medicare currently pays HMOs a capitated amount for each enrollee based on average fee-for-service spending in the enrollee's demographic group. ORD's selection studies showed that HMO enrollees tend to be healthier than average, indicating that capitation amounts may be too high. Through ORD-supported research, several methods of adjusting for an enrollee's relative health risk have been developed. These methods of risk-adjusting managed care payment are being tested in ORD demonstrations across the country in the next few years. These include ACGs and DCGs, as well as other risk adjusters based on more clinical data or survey data.

Outpatient Payment Reform. Hospital outpatient departments are currently paid by Medicare on a cost basis. The availability of Ambulatory Patient Groups (APGs), developed by ORD-sponsored research, has made prospective payment methods now possible. HCFA recently submitted a Report to Congress recommending legislation that would permit such payment reform.

Nursing-Home Payment Reform. An innovative payment classification system developed through ORD has the potential for significantly changing payment in various care settings. Resource Utilization Groups (RUGs) classifies patients based on costs according to the relationship of their various medical, functional, and personal characteristics and their daily use of staff time. RUGs originally were developed for reimbursement of care received by Medicaid residents in nursing homes. More recently, the concept was adapted and refined for paying for Medicare-covered patient care in certified skilled nursing facilities. A six-state ORD demonstration project is underway to pay nursing homes for Medicare and Medicaid patients on a prospective basis tied largely to residents' needs.

Centers of Excellence. ORD has developed and demonstrated negotiated package prices for all services during episodes of high-cost/high volume surgeries (heart bypass and cataract), aimed at reducing spending by the program and its beneficiaries and providing high quality services. As a direct result of successful ORD testing, the centers of excellence approach is part of the President's legislative package.

DELIVERY

HMO Participation. Originally, Medicare was essentially a fee-for-service program, with very limited enrollment in the incentive-payment HMOs authorized under section 1876 of the Social Security Act. Through an extensive demonstration effort, ORD tested the use of capitation for HMOs participating in Medicare. This pioneering effort demonstrated to plans, Congress, and the executive branch that HMO participation in Medicare on a capitated basis was a viable option. Today, about 260 plans participate and 10 percent of Medicare beneficiaries are enrolled.

Program for All-Inclusive Care for the Elderly (PACE) Demonstration. PACE replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly, most of whom are dually-eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by the participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary team case management through which access to and allocation of all health and long-term care services are arranged. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider.

Hospice. When the hospice movement was still in its infancy, ORD initiated a Medicare/Medicaid demonstration to determine whether hospice care could maximize patient autonomy during the last weeks of life and allow terminally ill patients to die with as much dignity as possible and relatively free of pain. Largely as a result of this successful demonstration effort, legislation established hospices as authorized Medicare providers. In 1993, about 215,000 Medicare beneficiaries used hospice care.

Swing-Bed. In the 1970s, the shortage of nursing home beds for frail elderly in many rural areas along with excess hospital bed capacity in those areas led ORD to test the swing-bed concept—the use of existing hospital staff and facilities to render both acute and long-term care. The successful demonstrations resulted in legislation that authorized the rural swing-bed program for small rural hospitals.

Home and Community-based Care. Beginning in the mid-1970s, ORD sponsored a series of innovative Medicare and Medicaid demonstrations throughout the country to test the use of community-based services as substitutes for more costly institutional care. These demonstrations served as the framework for the legislation authorizing the Medicaid 1915(b) waiver program in which home and community-based services may be covered services.

ACCESS AND QUALITY

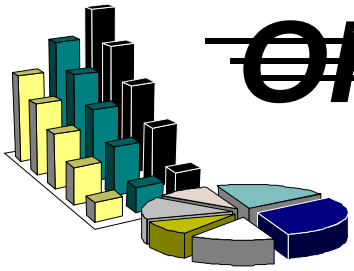
Expanded Eligibility. ORD launched a major demonstration effort to test innovative methods of providing health care to Medicaid beneficiaries. These projects include expanding Medicaid coverage to more people at no additional cost, exploring new delivery systems (often

including managed care) to provide access to quality health care, trying new administrative systems, and developing methods for monitoring. Over one dozen approved Statewide Medicaid health reform projects will ultimately provide coverage to about 7 million persons, including about 2.2 million low-income persons not otherwise eligible.

Access Measurement. ORD pioneered methods of measuring access to care for vulnerable populations. Using these methods, ORD has produced numerous studies documenting potential access problems among such vulnerable subgroups as persons with AIDS, the disabled, low-income, and racial minorities. These studies were among the first to document significant racial differences in access to care by Black Medicare beneficiaries and have resulted in a variety of HCFA initiatives to address these differentials.

Improved Care Campaigns. ORD has significantly contributed to the development of usable information on local rates of mammography and influenza immunizations in order to target areas for improvement. HCFA data were a key element in attracting the involvement of the First Lady in the Medicare mammography campaign, with ORD providing technical assistance directly to the First Lady and her staff.

Nursing-Home Quality of Care Measurement. ORD-sponsored research has developed outcome-oriented quality-of-care indicators for nursing homes. The result is an outcome-based quality improvement system and a set of quality-of-care indicators developed using resident-level assessment information.



ORD Accomplishments in the Making

The following highlights of the Office of Research and Demonstration's (ORD) major research directions are grouped into four primary research themes. In addition to the following focused research and demonstration projects, ORD continues to provide funding to support a variety of programs and activities that provide more general or overarching support to meet the research needs of the Health Care Financing Administration (HCFA) and the wider health research community.

THEME I - Monitoring and Evaluating Health System Performance: Access, Quality, Program Efficiency, and Costs

As the United States health care system continuously changes, there is a clear need for the development, design, and testing of ways to monitor and evaluate the performance of the health care system. Current ORD emphasis is on the design of a comprehensive monitoring and evaluation plan for HCFA programs, in addition to more issue-targeted projects. A number of critical dimensions are being included in the monitoring and evaluation efforts to understand how well the public programs are performing in terms of access to care, quality, efficiency, costs, and beneficiary satisfaction. This research theme includes two related efforts:

Monitoring and Evaluating the Public Programs : HCFA has developed a broad body of knowledge and tools to monitor program performance in specific areas (e.g., effects of physician payment reform on access and quality of care). Although ORD has made strides in monitoring and evaluating specific policy impacts, our past efforts have not been comprehensive, systematic or ongoing because they have focused primarily on responding to ad hoc Congressional mandates. ORD is developing a more comprehensive monitoring and evaluation plan for systematically examining the overall Medicare and Medicaid programs. In addition to evaluating Medicare and Medicaid in terms of traditional measures (i.e. cost-containment, quality, outcomes, access), this work also considers various HCFA beneficiary dimensions as evaluation criteria (such as beneficiary satisfaction and knowledge of health behaviors). Emphasis is being placed on how well Medicare and Medicaid meet the needs of specific groups of beneficiaries, including the disabled and vulnerable populations.

As part of the comprehensive monitoring and evaluation system, ORD research is also examining more specific policy issues within the HCFA programs. For example, as Medicare and Medicaid continue to pursue managed care options, on-going work is examining the cost-effectiveness of, quality of, and beneficiary satisfaction with managed care.

Developing Monitoring and Evaluation Tools : Without a reliable and ongoing monitoring effort, the evaluation of the performance of the health care system can only be sporadic and costly. However, the ability to perform these examinations is limited by a lack of appropriate indicators, or measures, of quality, access, satisfaction, and cost-effectiveness. Therefore, an important focus for this area of HCFA research is the development of tools required for ongoing monitoring of the health care system, including development of meaningful outcome and access indicators, the necessary data bases, techniques for handling large volumes of data, the statistical approaches, and the ongoing reporting system.

The following research objectives have been established to support this theme:

- Produce descriptive statistics on the health system's infrastructure.
- Produce descriptive statistics on populations of health care users.
- Develop monitoring and evaluation tools to support the evaluation of HCFA programs.
- Evaluate differences in access to care.

- Evaluate the impact of managed care on access to care, health care costs, and quality of care.

- Evaluate the effects of HCFA programs on beneficiary health status.

- Monitor fraud and abuse and program integrity.

THEME II -Improving Health Care Financing and Delivery Mechanisms

ORD recognizes that substantial research is needed to improve current health financing systems and to develop new payment, cost containment and financing systems for existing Federal programs. Growing costs in both the Medicare and Medicaid programs require that efforts continue to develop the next generation of financing and delivery systems to improve the efficiency and cost effectiveness of health care. At the same time, ORD is continuing ongoing research and demonstrations to refine existing payment systems.

Over the past decade, many Medicare research and demonstration projects aimed at reforming the program have concentrated on payment reform. The most notable examples have been the development of a prospective payment system for hospitals and the physician payment reform efforts. However, the basic Medicare program, both in terms of the delivery system and the benefit package, has remained relatively unchanged for 25 years. While ORD continues to work on basic program refinements to various aspects of Medicare, additional research is needed to plan and develop the future Medicare program to better meet the diverse and changing needs of the growing elderly and disabled populations.

As HCFA develops these new approaches to delivery systems and benefit packages, ORD has the option of both examining structural changes to the basic Medicare program and experimenting with new options for Medicare beneficiaries. Increasing the efficiency and effectiveness of Medicare requires research and demon strations that: (1) explore alternatives to the fee-for-service system, (2) develop, test and evaluate multiple and diverse products, and (3) focus on the beneficiary in terms of promoting improved health status, responding to special needs, and simplifying administration.

The following research objectives have been established to support this theme:

- Develop new payment, quality assurance, and delivery systems for acute care, post-acute care, and long-term care.

- Develop new approaches for managing high cost and high risk patients.

- Develop new delivery models for managed care.

- Develop models of beneficiary-directed care.

- Develop improved risk adjustment mechanisms for payments to managed care organizations.

- Develop other innovative delivery and payment models.

THEME III - Meeting the Needs of Vulnerable Populations

An important focus of ORD's research and demonstration projects is the development of new approaches to meet the health care needs of vulnerable populations. These efforts are focused on issues of access, delivery systems, and financing. Vulnerable populations include minorities, the frail elderly, low income persons, high-risk pregnant women and their infants and children, underserved individuals (including urban inner city, rural, migrant workers, refugees, and frontier residents), as well as the frail elderly and individuals with disabilities who require long-term care.

The following research objectives have been established to support this theme:

- Extend Medicaid coverage to new populations (State health reform demonstrations).

- Develop new payment and delivery systems that integrate acute and long-term care.

- Develop delivery and financing models for populations with special needs.

- Understand and improve long-term care financing.

- Develop new payment and delivery models for health care in rural areas.

THEME IV - Information to Improve Consumer Choice and Health Status

Using HCFA data and other information to improve beneficiaries' knowledge and ability to make more informed health care choices, both in the health plans they select and in the services they use, is part of a long-term commitment by HCFA to change and improve communication of information to beneficiaries. These information systems are instrumental in meeting HCFA's Strategic Plan goals of better understanding beneficiaries' health and information needs and of improving their health status. The development of information systems to support consumer choice also is being applied to provide health plans and health care providers with more information on consumer preferences and needs. Finally, expanded consumer information and education programs is improving beneficiaries' ability to choose between expanded managed care options in the future.

The following projects have been established to support this theme:

- Produce information to assist providers and beneficiaries in assessing medical treatment options.

- Produce information to assist beneficiaries in choice of health care plans.

- Provide information to improve beneficiaries' health status.

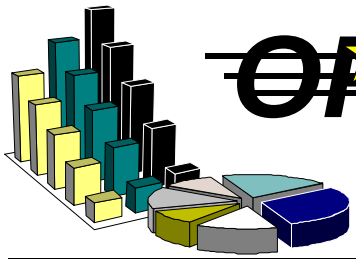
Theme IV emphasizes three areas of research:

Information for Consumer Choice : Current approaches to creating and providing such information under public and private insurance programs are numerous and varied. Little is known about the factors underlying consumer choice of health plans and about the effect of choice on plan switching, selection, and premium costs. Similarly, standardized information on the quality of plan performance and on more effective service delivery is also limited. This part of ORD's research agenda includes development and testing of improved information resources that enable consumers to choose among health plans and providers based on their relative value and quality. This same information may also be shared with health plans and other appropriate "local" entities (for example, health care providers) to assist them in being more responsive to the preferences and needs of beneficiaries.

Information for Health Status : ORD research is also examining the potential for using HCFA claims and survey data to improve the ability of Medicare and Medicaid beneficiaries and their physicians to make more informed health care choices in order to improve beneficiary health status. ORD is building on research currently underway in connection with HCFA's consumer information strategy that examines variation in use of preventive services, such as influenza vaccination and mammography, and treatments and alternatives related to breast cancer and prostate disease. Research and demonstration projects are applying the results of research regarding access, quality of care, and the use of preventive and other appropriate services to the development of information resources for use by physicians and beneficiaries. These initiatives include evaluations of the impact of these information tools and technologies in improving beneficiaries' health status.

THEME V - HCFA On-Line

One of HCFA's highest priorities is the HCFA On-Line initiative, a comprehensive communications strategy that will strengthen interaction between HCFA and both its beneficiaries and the health care community as a whole. HCFA On-Line originated from HCFA's Strategic Plan and is a major vehicle for carrying out two of our strategic goals: (1) ensuring that programs and services respond to beneficiaries' health care needs, and (2) providing leadership in health care information resources management. ORD is initiating a range of studies to identify and measure the communication needs and preferences of its audience and highlight those areas most in need of attention. ORD is also initiating projects to support the monitoring and evaluation of HCFA On-Line once it is implemented.



ORD Research Fact Sheet

The Medicare Beneficiary Health Status Registry

The Medicare Beneficiary Health Status Registry (Registry) is a data collection system designed to survey a large sample of Medicare beneficiaries. The main objectives of the Registry are 1) to monitor the health status of beneficiaries throughout their enrollment in the Medicare program and 2) to identify potential barriers affecting access to quality health care. A unique aspect of the Registry is the longitudinal study design coupled with the linkage to Medicare administrative data. The Registry differs from other surveys that collect data on health status because of its (1) large sample size and (2) long-term longitudinal (cohort) follow-up of sampled beneficiaries.

Through the Registry, HCFA will be able to augment the information obtained from the claims database to perform more reliable and useful analyses for policy development. Included in such analyses would be studies of population-based estimates of health status; development of methods for risk adjustment; monitoring health transitions; evaluation of treatment choices on health and utilization of services; and evaluation of the impact of changes in health delivery systems on beneficiaries and their health.

The data can be used to study access to care and to identify barriers that may affect access for vulnerable subgroups of the Medicare population such as blacks, Hispanics, low-income beneficiaries, and beneficiaries who reside in rural areas. The Registry can monitor HCFA's efforts to improve the quality of health care services provided to beneficiaries. By tracking health status data from the Registry linked to Medicare administrative files, it will be possible to evaluate the impact of the quality and types of health care services received by beneficiaries on their overall health status. In this manner, the Registry can also be responsive to the health information needs related to program activities in the Regions and PROs.

In addition to providing information on the general health status of Medicare beneficiaries over time, the Registry can serve to monitor the impact of changes in the Medicare program on our beneficiaries. It will be crucial to be able to have baseline and follow-up data on beneficiaries as more and more Medicare enrollees move into managed care.

Health outcomes are particularly important for HCFA to monitor as part of the Consumer Information Strategy (CIS). Are the specific CIS initiatives really making a difference in the health behaviors and health status of beneficiaries? The Registry is well-positioned to monitor CIS activities and their impact on beneficiary outreach and educational efforts. The Registry can serve a major function with respect to its ability to ask beneficiaries questions about information pertaining to a recent campaign, such as mammography, in a timely manner. Modules can be developed as part of the CIS activity. The data can then be used to evaluate the impact of the campaign on Medicare beneficiaries.

In a number of ways, the Registry can serve as a template for developing a model health care data collection system. The Registry has the special capability to be more responsive to changing health care data needs than most of the existing national surveys. The Registry's design allows for developing and implementing questionnaire modules that can be used to respond to emerging issues related to health status concerns for Medicare beneficiaries.

ORD Research Fact Sheet

Monitoring and Evaluating Access to Care

Monitoring the Impact of Program Changes

The Office of Research and Demonstrations has a broad and varied approach to monitoring the impact of program changes on access. To illustrate, in response to a Congressional mandate in OBRA 1989, ORD produced a Report to Congress on Access. The original purpose of this report was to monitor and report annually to Congress on changes in utilization and access as a result of implementation of the Medicare Fee Schedule (MFS). The sixth annual report will be released in 1996. In the process of doing the annual report to Congress, substantial differences in utilization and access for vulnerable segments of the Medicare population were observed. In particular, utilization differences exist between White and Black beneficiaries and between low and high income beneficiaries.

Racial Differentials and Access. While results from studies on access show that Medicare has gone a long way to equalize access to care, major differences in utilization (a key measure of access to care) between Black and White beneficiaries remain. For example, Black beneficiaries have substantially lower utilization rates of many elective procedures, which may reflect differences in access. At the same time, Black beneficiaries have higher rates of non-elective procedures, which may reflect delayed diagnosis or initial treatment, or inadequate medical and/or follow-up care.

Income Effects. Income is a widely used proxy for socioeconomic status (SES). As part of the 1995 annual Report to Congress, a new series of ORD-sponsored analyses was undertaken to explore the impact of income on utilization patterns. The most important new knowledge gained is that lower SES, in and of itself, is a barrier to care for all Medicare population groups, regardless of race.

Future Monitoring and Evaluation Activities

In the process of conducting the analyses of the impact of the MFS on access, it became clear that differences that exist between vulnerable groups existed prior to implementation of the MFS. Consequently, in addition to monitoring the impact of specific program changes, ORD is also developing a multi-pronged approach for continuous access monitoring and evaluation.

As part of this continuous monitoring effort, a major set of activities involves the development of new access indicators for both Medicare and Medicaid. While ORD has made strides in developing and refining access indicators, new ones are needed to monitor access to care, particularly in ambulatory settings and in managed care. Examples include clinically-based indicators, beneficiary self-reports, referral-sensitive surgeries and hospitalizations for ambulatory care sensitive conditions, such as asthma and diabetes. The monitoring system also will include analyses that will highlight population subgroups for whom there appear to be potential access problems.

The analyses that are being conducted as part of the access monitoring effort have enhanced our understanding of the health care needs of vulnerable populations, and provided new information on the related effects of other forces, including the advent of new medical technologies, changing demographics and modifications in coverage and payment policies. Results have substantially altered the ways in which researchers and policy makers assess access to care.

ORD Research Fact Sheet

HMO Evaluation

The HMO issues related to beneficiary selection, spillover, satisfaction, disenrollment and quality are of continuing interest to the current Medicare managed care debate. ORD has developed an analytic plan to provide current information related to these issues. The research strategy calls for analyses that can be done relatively quickly, but that can also be repeated on an ongoing basis to monitor HMOs over time.

Selection. In order to determine whether and to what extent HMOs are experiencing favorable or adverse selection, several analyses are being conducted comparing new HMO enrollees to persons in fee-for-service: mortality rates; pre-enrollment utilization; and self-reported health status. The mortality rate comparison addresses whether HMO enrollees have lower mortality rates than persons in fee-for-service. The pre-enrollment utilization analysis focuses on hospitalization rates and costs for the period prior to HMO enrollment for enrollees versus non-enrollees. Using risk adjustor methodologies, ORD is also addressing whether and by how much predicted program costs of new enrollees are different from those for nonenrollees. For the self-reported health and functional status analysis, data from the Medicare Current Beneficiary Survey (MCBS) is being used to compare HMO enrollee responses to information from survey respondents in fee-for-service.

Spillover. This analysis examines the impact of managed care penetration on Medicare costs in the fee-for-service sector. Factors that influence Medicare HMO penetration are also being analyzed.

Beneficiary Satisfaction. Data from the MCBS is being used to compare beneficiary satisfaction for HMO enrollees with persons in fee-for-service, with controls for health status, functional status, and demographic variables.

Disenrollment. This analysis examines characteristics of persons who disenroll from HMOs by length of enrollment, type of plan, geographic area, and other relevant variables. Utilization of HMO disenrollees is being compared to that of persons continuously in fee-for-service to determine whether relatively high service users are disenrolling.

Quality. Unlike earlier studies of HMOs, the quality of care analysis focuses on outcomes of care rather than process. Initial work on this area has been implemented and will become part of the monitoring effort in the future.

The HMO evaluation is being repeated periodically to assess issues important to our beneficiaries. As enrollment in HMOs increases, such assessments remain critical to the Medicare program.

ORD Research Fact Sheet

Medicare Competitive Pricing

ORD is designing a Medicare Competitive Pricing Demonstration initiative, a key component of its managed care research agenda. Demonstrations will test:

- new ways of setting Medicare payments for managed care plans utilizing competitive market forces;
- providing beneficiaries with comparative information on optional ways of obtaining Medicare benefits; and
- use of a third party contractor to enroll beneficiaries who choose managed care plans.

In targeted areas, all HCFA-contracted health plans will submit a bid price for a specified Medicare benefit package. HCFA's payment contribution to all plans in the area will then be determined. Plans with a price below the contribution level may offer additional benefits while those above will charge an additional premium to cover the difference.

Several of the important design features of the pricing demonstration that include: (1) site selection; (2) bidding specifications and requirements; (3) evaluation of bids; and (4) setting the Medicare payment level.

As a result of competitive pricing, more health plan options are expected as well as different benefit arrangements. Thus as part of the competitive pricing demonstrations, a coordinated open enrollment will be conducted. It will consist of various outreach and education strategies designed to improve beneficiary understanding of health plan options. Printed materials describing and comparing the features of all available health plans as well as fee for service will be sent to all beneficiaries. Beneficiaries may enroll in a health plan by completing an enrollment form and giving it to the third party enrollment contractor.

ORD is conducting an evaluation of the Medicare Competitive Pricing initiative. Control or comparison sites are being identified to assess the effectiveness of the pricing and open enrollment processes utilized in the demonstration sites. The evaluation is designed to produce important results quickly to guide any nationwide implementation of coordinated open enrollment or competitive pricing that may occur.

Research Fact Sheet

Multistate Nursing Home Case-Mix Payment and Quality Demonstration

This demonstration builds upon past and current HCFA initiatives with case-mix prospective payment systems for nursing homes. The purpose is to design, implement and evaluate a combined Medicare and Medicaid nursing home payment and quality monitoring system. For the first time, Medicare will pay nursing homes largely on the basis of residents' resource needs. Using a single form to capture information for payment rates and quality indicators, this innovative system is expected to enhance access to care, improve the equity and predictability of payment amounts, streamline the payment and quality processes, and ultimately improve the quality of patient care.

Systems Development and Design

A common classification method, known as Resource Utilization Groups, Version III or (RUGS-III), is used to set prospectively determined rates for a large portion of the payment amounts to skilled nursing facilities (SNFs) under the Medicare and Medicaid programs. Classification is based on residents' clinical conditions; extent of services needed, such as rehabilitation, respirator/ventilator care or tube feedings; and functional status, such as the amount of support needed to eat or toilet.

Under the new system, SNFs will know in advance how much HCFA will pay for each Medicare patient and whether Medicare will cover the patient at all. Claims for payment no longer will be retroactively denied based on the patient's condition. Patients falling into one of the 26 specified groups automatically will be covered under Medicare.

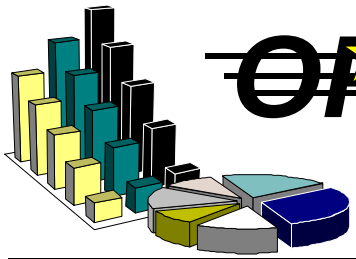
Unlike the current Medicare system, which pays the same amount per resident based on each facility's average costs, the new system pays different amounts for residents of the same facility based on each resident's resource needs. For example, nursing service payment amounts in this system are three times higher for bed-ridden, severely ill patients needing a variety of therapies than for ambulatory patients who need only post-hospital monitoring and surgical wound treatment.

The system also significantly enhances the quality assurance process in SNFs. Data for measuring quality of care will come from an expanded version of the standardized resident assessment instrument currently used by States for all nursing home residents. The same tool is used to determine Medicare and Medicaid payment. The instrument, which measures residents' needs, strengths and preferences, is also used in care planning.

In the developmental phase of the demonstration, data from the assessment instruments were used to create 30 facility-level quality indicators. Under the demonstration, these indicators will help the facilities benchmark their own performance and help Medicare and Medicaid target nursing home surveys. Facilities providing high-quality care would be surveyed less frequently, while those with problems would have more frequent inspections. The evaluation of the demonstration will provide further information about the effectiveness of the quality indicators in the survey process.

Implementation

The system is being tested in SNFs in Kansas, Maine, Mississippi, New York, South Dakota, and Texas. Phase III of the demonstration will incorporate therapies into the new prospective rates. It is anticipated that 1,000 facilities may be participating in the demonstration by the time enrollment closes in 1997.



ORD Research Fact Sheet

Multistate Nursing Home Case-Mix Payment and Quality Demonstration, con't.

Evaluation

The evaluation contract was awarded in fall 1994 and will determine if the changes in the patient assessment, payment and quality assurance systems were able to:

- improve the quality of care without reducing access or increasing program costs
- improve needed access without reducing quality of care or increasing program costs
- improve the equity of payment to providers without reducing quality or access or increasing program costs
- positively affect total Medicare expenditures (including use of acute care) for Medicare beneficiaries who use the nursing home system.

Internet Information Site

As a distribution agent for the Health Care Financing Administration, the Center for Health Systems Research and Analysis at the University of Wisconsin - Madison has established an Internet site to store and distribute technical information related to the assessment instrument being used in this demonstration. The URL for this site is: **http://linear.chsra.wisc.edu/mds_info.htm** .

ORD Research Fact Sheet

Medicare Choices Demonstration

The Medicare Choices demonstration is designed to give Medicare beneficiaries expanded choices among types of managed care plans and test new ways to pay for managed care.

Beneficiaries presently can obtain managed care through the nearly 300 health maintenance organizations nationwide that participate in the Medicare program. Under the Choices demonstration, beneficiaries living in selected cities and rural areas will have the option of joining a much wider variety of managed care plans, most of which currently are not eligible to participate in the Medicare program.

The Medicare Choices demonstration also gives HCFA a head start on developing solutions to a wide range of implementation issues (such as risk sharing, payment methods, certification requirements, and quality monitoring systems) that would be associated with some of the legislative expansions of Medicare managed care currently under consideration. The Choices demonstration is likely to significantly expand the managed care options available to beneficiaries living in the demonstration sites.

The Application Process: A range of managed care organizations (including preferred provider organizations (PPOs), health maintenance organizations (HMOs), and provider sponsored networks (PSNs)) were encouraged to submit innovative managed care options (such as open-ended HMOs, multiple options, risk adjusted models, and new payment methods) in the form of a short pre-application. In response to this solicitation, HCFA received 372 pre-applications. These were narrowed down to 52 pre-applicants, which were sent letters inviting them to submit full applications.

Site Awards: Following a rigorous review process, a total of 25 managed care organizations were selected as candidates for site awards. They include 9 provider sponsored networks, 8 provider-owned HMOs or providers with HMO partners, and 8 other HMOs or PPOs. Most of the candidates for site awards are located in market areas that currently have limited Medicare enrollment in managed care and potential for expanding beneficiary choices based on available private-sector options. The areas are: San Diego, CA; Jacksonville and Orlando, FL; Atlanta, GA; New Orleans, LA; Columbus, OH; Philadelphia, PA; and Houston, TX. Award candidate organizations also are located in rural areas in Illinois, Montana, New York, North Carolina, and Virginia. All 25 site award candidates are listed below.

The selected organizations will begin the final steps of the Choices Demonstration site award process in late-April. This includes negotiations with HCFA, as well as obtaining certification by HCFA's Office of Managed Care. Once plans get certified and meet any special terms and conditions, they become Choices Demonstration sites and may begin enrolling Medicare beneficiaries. Some sites might begin as early as summer 1996, with the remainder expected to be in operation by December 1996.

The site award candidates by metropolitan areas are:

Atlanta, GA

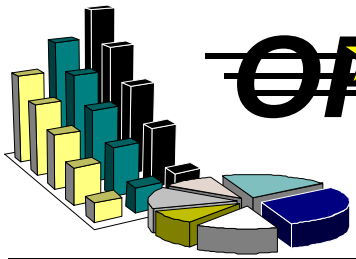
Georgia Baptist Health Care System
The Morgan Health Group, Inc./NYLCare
St. Joseph's Hospital
Value Health, Inc.

Columbus, OH

IDS Consortium
Mount Carmel Health Systems
Nationwide HMO

Houston, TX

Memorial Sisters of Charity Health Network
NYLCare of Houston



ORD Research Fact Sheet

Medicare Choices Demonstration, con't.

Jacksonville, FL
HealthCare USA

New Orleans, LA
Advantage Health Care
New Orleans Regional Physician Hospital (Peoples)
Oschner/Sisters of Charity Health Plan
Value Health, Inc.

Orlando, FL
Florida Hospital HealthCare System

Philadelphia, PA
Crozier-Keystone Health Systems, IDS
Health Partners of Philadelphia
Independence Blue Cross
Mercy Health Corporation

San Diego, CA
University of California at San Diego HealthCare

The site award candidates in rural areas are:
Compre-Care, Inc. (Upstate New York)
Health Alliance Medical Plans, Inc. (Illinois)
Qual-Choice of North Carolina
Qual-Choice of Virginia
Yellowstone Community Health, Inc. (Montana)

ORD Research Fact Sheet

Risk Adjuster Research and Demonstrations

ORD has a long history of sponsoring research on the development of accurate and feasible methods for adjusting payments to HMOs to reduce incentives for risk selection ("cream skimming") and to account for differences in health status among enrollees. Risk adjustment methods can help HCFA improve access to care and enroll more Medicare beneficiaries in managed care as ways of constraining the growth of Medicare program expenditures.

Current risk adjustment projects in ORD are aimed at the over 65 age group to a large extent, with several projects also directed at the under 65 group or special populations. Projects generally use diagnoses from a prior year to predict program payments for a subsequent year (ie., predictive or prospective models), or alternatively use diagnoses or cost information from a current year to adjust payments for that year (concurrent or retrospective methods).

Two projects for the over 65 population include further development of Diagnostic Cost Groups (DCGs) and Ambulatory Care Groups (ACGs). As a result of changes to these models, both of these approaches incorporate diagnostic information from inpatient, outpatient, and physician encounters in a prior year to predict expected costs in a subsequent year. Results from both of these projects will be available by mid-1996.

Health status measures from the Medicare Current Beneficiary Survey are being assessed for their usefulness in improving payment approaches. Measures of chronic illness (e.g., heart disease, cancer, and stroke) taken from administrative data are also being tested. A report on these approaches will be available in 1997.

A number of actuarial methods for adjusting payment rates are also being assessed. These include: reinsurance, partial capitation, select and ultimate rates, and experience rating. Reinsurance and partial capitation may be especially helpful for adjusting payments for plans in a start-up phase or for smaller plans (such as those located in rural areas). A next step in research on risk adjustment methods is the evaluation of combinations of approaches by simulations and demonstrations.

Reinsurance is being tested in a demonstration of outlier payments, conducted with three managed care plans in Seattle, Washington. Plans that have enrollees with costs exceeding a threshold in a year may be paid additional payments (up to 2% of the AAPCC) to cover those costs. Plans will be responsible for covering a set proportion of the costs (e.g., 30% or more) and must establish a method for administering the outlier payments.

Risk adjustment systems are part of two large scale demonstrations being implemented by HCFA. The first, Medicare Choices, tests direct contracting between Medicare and a variety of health plans, including PPOs and provider sponsored networks. Risk adjustment, partial capitation, reinsurance, and other payment methods are being implemented. The second demonstration tests competitive pricing for HMOs and includes a risk adjustment approach.

ORD Research Fact Sheet

Medicare's OASIS: Standardized Outcome and Assessment Information Set for Home Health Care

HCFA has proposed the Outcome and Assessment Information Set (OASIS) for purposes of outcome-based quality improvement as part of the new Conditions of Participation for Home Health Agencies. OASIS resulted from a five-year study by the University of Colorado to develop outcome measures for home care (funded by ORD and the Robert Wood Johnson Foundation). This data set included 73 items. HCFA convened a task force of home care experts to review these items and add selected items judged important for patient assessment. This resulted in a revised 79-item version of the data set.

The refined version of the OASIS is currently being used in a national demonstration of Outcome-Based Quality Improvement (OBQI) that ORD is sponsoring and the University of Colorado is administering. The experience of the 50 demonstration agencies in using the OASIS for purposes of collecting outcome data is being taken into consideration in the final revisions of the OASIS. Findings from this project are guiding the implementation of the national approach for outcome-based quality improvement, in which Medicare-certified home health agencies report data used to determine and profile patient outcomes for their agency. This approach helps streamline the Medicare certification process and is consistent with the HCFA Medicare Home Health Initiative.

The OASIS consists of patient identifying information, data items for assessing patient health and functional status, and items needed for risk factor adjustment. Included are health status and functional status which apply to all Medicare home health patients (global items) and other items which apply to specific groups of patients (focused items). These specific patient groups are called quality indicator groups (QUIGs). The QUIG grouping was developed by the University of Colorado to specify a set of outcome quality measures appropriate for all (or most) of the patients within a group (or QUIG). The groups (e.g., orthopedic patients) are defined by conditions that are frequently treated in Medicare home health care and are important from a quality assurance perspective. The groups are exhaustive allowing all patients to be classified.

Currently, all demonstration agencies are collecting the OASIS data. The first round of agency outcome reports will be produced in the end of 1996.

ORD Research Fact Sheet

Medicare Cardiovascular and Orthopedic Participating Centers of Excellence Demonstration

Premier cardiovascular and orthopedic facilities offering beneficiary incentives and reduced costs to the Medicare program will receive "Participating Centers of Excellence" designations under a new demonstration project being undertaken by the Health Care Financing Administration. The goal of the demonstration is to encourage beneficiaries and referring physicians to use these premiere facilities that provide high-quality services while offering lower prices to the government. Participating facilities are expected to achieve cost efficiencies through better coordination of services and increased volume of both Medicare and non-Medicare patients as a result of the special designation.

The demonstration also will test the use of systems for administration, claims processing and payment and the routine monitoring of care. The overall performance of participating centers of excellence will be evaluated by HCFA in a separate set of activities.

Background. The demonstration has its origins in the Medicare Participating Heart Bypass Center Demonstration and the Cataract Alternative Payment Demonstration. Both ended this Spring.

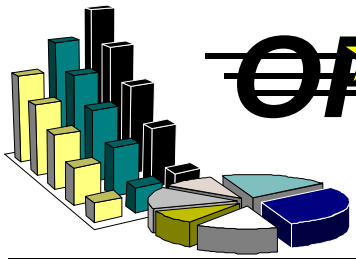
Under the heart bypass demonstration, seven participating bypass centers received negotiated bundled payments for Medicare patients discharged under Diagnosis Related Groups (DRGs) 106 and 107. Numerous studies have found a relationship between institutional volume and beneficial outcomes for bypass surgery. Yet, analysis of Medicare claims data in the late 1980s showed that one-third of Medicare bypass surgeries took place at hospitals performing fewer than 50 Medicare cases per year. It was therefore believed that surgical outcomes could be improved by greater regionalization of heart surgery at selected centers. (The Extramural Research Report on the heart bypass demonstration can be downloaded at: **http://www.hcfa.gov/pubforms/ord.html**.)

Just as outcomes are related to volume, costs per case can be expected to decrease as a hospital's volume increases, spreading high fixed costs over more cases. Moreover, studies have shown that average costs and lengths of stay for bypass surgery fall with increases in patient volume, reducing variable costs as well.

Results from the Medicare Participating Heart Bypass Center Demonstration showed an estimated $38 million savings for Medicare for 9,900 coronary artery bypass grafts (CABGs) at 7 sites. These savings were largely the result of changes in patient management, such as shorter lengths of stay, substitution of generic drugs, standardization of equipment and other changes. Cost savings were achieved with no adverse impacts on mortality or other outcomes.

The new demonstration also has roots in the cataract surgery alternative payment demonstration, which was implemented at 4 sites in 3 cities. Results showed an estimated Medicare savings of more than $500,000 for some 7,000 surgeries.

Demonstration Design. The demonstration sites will be selected on a regional basis and must meet volume and high-quality standards. HCFA will negotiate package prices for hospital and related physician services provided during episodes of care for selected cardiovascular procedures and total joint replacement procedures as defined by DRGs and International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes. The cardiovascular services include heart bypass graft surgery (DRGs 106 and 107), cardiac valve procedures (DRGs 104 and 105), angioplasty (DRG 112) and cardiac catheterization (DRGs 124 and 125). The orthopedic procedures are total hip replacement and total knee replacement (DRGs 209 and 471 focusing on specific ICD-9 codes).



ORD Research Fact Sheet

Medicare Cardiovascular and Orthopedic Participating Centers of Excellence Demonstration, con't.

Hospitals and associated physicians can apply for these bundled payment arrangements for either group of inpatient services or both. The negotiated global rate will be accepted as payment in full. The resulting prices will represent a substantial savings to the Medicare program.

Participating institutions will be designated as a Medicare Participating Center of Excellence, which can be used as a potential marketing tool to change referral patterns and increase patient volume. Beneficiaries will continue to have free choice of providers. At the same time, the Centers are expected to offer beneficiaries incentives, such as lower cost-sharing, simplified claims processing and transportation to and from the facility.

Demonstration Site Selection. The opportunity to participate in the new demonstration is open to selected hospitals in States served by HCFA's San Francisco and Chicago Regional Offices: Arizona, California, Hawaii, Michigan, Illinois, Indiana, Minnesota, Nevada, Ohio and Wisconsin. To be eligible, the facilities must perform at least 250 heart bypass surgeries per year for the cardiac option, of which 80 are performed on Medicare beneficiaries, and/or at least 50 Medicare hip replacements and 50 Medicare knee replacements annually for the orthopedic option. Potentially eligible institutions in those States were mailed HCFA's invitational solicitation on March 25. Preapplications from interested organizations are due to HCFA postmarked May 10.

Following intensive review, invitations to submit a full application will be extended to providers who can document in their preapplications that they meet the basic qualifications for participation and have the potential to submit well-designed proposals addressing the final review and site selection criteria. Other information to be examined in extending invitations to submit full applications include facilities' capacity to handle potential increases in volume and the ability of their internal data systems to support the planned evaluation. Successful applicants will demonstrate the ability to deliver the highest quality of care efficiently and implement and manage a successful demonstration. Up to 100 facilities may be designated as a Medicare Participating Center of Excellence.

ORD Research Fact Sheet

National Home Health Agency Prospective Payment Demonstration

ORD is sponsoring the National Home Health Agency Prospective Payment Demonstration, which tests two alternative methods of paying home health agencies (HHAs) on a prospective basis for services furnished under the Medicare program. Phase I of the demonstration tested per-visit prospective payment by visit discipline. Phase II of the demonstration, which began in June 1995, is testing per-episode prospective payment. HHA participation in the demonstration has been voluntary. In each phase, HHAs that agree to participate are randomly assigned either to the prospective payment method or to a control group that continues to be reimbursed in accordance with the Medicare current retrospective cost system. Each HHA participates in the demonstration for 3 years.

In Phase I, a per-visit payment method was tested that sets a separate rate for each of six types of home health visits (i.e., skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services). Following the initial HHA recruitment, operations of the first phase of the demonstration began October 1, 1990. Forty-seven HHAs participated in Phase I. Although the evaluation found that treatment group agencies (i.e., those being reimbursed through prospective payment rates) were more likely than control agencies to keep their cost increases below inflation, the differences in costs between the treatment and control agencies were fairly small. The demonstration had no significant effect on the number of visits provided, quality of care, access to care, and other Medicare costs.

HHAs participating in Phase II of the demonstration were assigned to a control group that receives reimbursement in accordance with the existing Medicare retrospective cost method or a per-episode payment group that receives and agency-specific episode payment based on 120 days of care and outlier payment for episodes that extend beyond 120 days. Outlier visits are reimbursed at per-visit prospective rates. A new episode of care has not begun until there has been a gap in home health service for 45 or more days after the initial 120 days. Agencies receiving per-episode payment are subject to stop-loss and profit-sharing adjustment, as well as case-mix adjustments. Since with per-episode prospective payment there is an incentive to underserve patients, a scaled-down version of the outcome-based quality assurance system (Outcome and Assessment Information Set) that HCFA will be implementing for Medicare HHAs is being used in the demonstration. The first group of agencies participating in Phase II began collecting baseline data March 1, 1995, and began demonstration operations June 1, 1995. Information from this demonstration, supplemented with further research related to determining what resources are used during a home health visit and developing a case-mix adjustor, will be used to shape a national prospective payment system for Medicare home health care.

ORD Research Fact Sheet

State Health Reform Demonstrations

A growing number of States have requested to use the authority under Section 1115 of the Social Security Act to launch statewide Medicaid demonstration programs. Through the flexibility afforded under the section 1115 demonstration program, States are working in partnership with HCFA to design and implement innovative managed care approaches for Medicaid beneficiaries and the low-income uninsured. These various approaches now serve as models for States interested in exploring managed care alternatives for their Medicaid and low-income populations. The flexibility afforded under the 1115 demonstrations has allowed States to experiment with methods to improve the efficiency with which they provide care. Many States are seeking to use the resulting savings to cover additional populations with unmet health care needs.

For example, expansion of health care coverage to the low-income uninsured is growing tremendously under these demonstrations. As a result of the demonstrations approved during this Administration, nearly 2.2 million newly eligible, low-income individuals have (or will have when all of the demonstrations are implemented) coverage under the Medicaid program. This is in addition to the over 4.3 million previously-enrolled Medicaid beneficiaries receiving (or expecting to receive) services under these projects.

To maximize what is learned about the effects of these projects for future health care reform activities, ORD has made great strides in developing models for monitoring the quality of care and services. These models include the following methods of measuring effects on beneficiaries and providing direct technical assistance to States on data-driven quality monitoring techniques and encounter data:

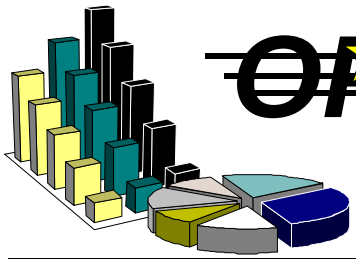
- **Technical Assistance.** ORD has contracted with MedStat to provide technical assistance to States in the areas of encounter data system development and utilization and other quality assurance methodologies. Further, MedStat has been charged with developing three resource guides: a guide for States on how to develop and implement an encounter data system and how to use that system; a guide for Regional Offices to use in monitoring quality; and a guide for Regional Offices to monitor State development and use of encounter data systems. Under a National Governors Association (NGA) contract, ORD is developing a Best Practices Guide for States to share experiences and two training sessions, "Contracting with Managed Care Plans" and "Encounter Data Systems."

- **GeoAccess.** ORD has purchased state-of-the art software, GeoAccess, to monitor access and provider capacity in the demonstrations in an effort to ensure that care is available to beneficiaries.

- **Monitoring Guides.** In conjunction with other HCFA components, ORD is developing a series of Regional Office guides for monitoring Medicaid managed care and other 1115 demonstration issues, including marketing, client education, enrollment, delivery system, access, financial issues, and fraud and abuse.

In addition, formal evaluations are further determining the impact of the demonstrations. ORD has awarded three 5-year contracts to evaluate 11 of the implemented demonstrations. Each evaluation, using onsite visits by the evaluators, is designed to examine the impacts of the demonstrations on: the expansion eligibles; the number of uninsured and underinsured individuals in the State; improved access; quality, including health status, process of care, and satisfaction; and the cost of services.

As ORD continues to work in partnership with States on developing and implementing these innovative demonstrations, one of our most important goals is improved communication. Interactions with States have shown how important



ORD Research Fact Sheet

State Health Health Reform Demonstrations, con't.

early dialogue, technical assistance, and well-planned implementation can be to the ultimate success of a demonstration. To assist States in their health care initiatives and in gaining 1115 demonstration waivers, ORD has created guides on proposal development and implementation and has worked with States to implement their programs. ORD also remains committed to continue to improve communication with beneficiary, advocacy and provider groups. Staff have met with groups including representatives of: the homeless; hospital associations; primary health care associations; nurse practitioners; pharmacists; chiropractors; the disabled; and the mentally challenged. Their input has been incorporated into the review and approval process. ORD continues to take an active role in educating the States and the public on lessons learned from the demonstrations.

ORD Research Fact Sheet

Medicaid Research Initiatives

ORD has initiated a research program that concentrates on access to, costs of, and quality of health services for low-income women and children, the disabled, and the poor elderly. These groups are particularly vulnerable to potential access problems because of their socio-economic status and higher likelihood of poor health status. To evaluate access to, costs of, and quality of health services, ORD has participated in the development of a database, the State Medicaid Research Files (SMRFs), that can be used for research purposes. SMRFs are files with a uniform format that make Medicaid research more feasible. Initially, Medicaid claims data spanning 12 years from four States were reformatted into SMRFs. In 1992, 22 more States were added to this database.

Using the SMRF database and other national databases (such as the Third National Health and Nutrition Examination Survey (NHANES III) and the National Maternal and Infant Health Survey (NMIHS)), the ORD research agenda focuses on:

- access to, use of, and costs of health services for children;
- use of prescription medications to treat specific diseases; and
- evaluation of the health of Medicaid-eligible and uninsured women and children.

ORD Medicaid research projects include:

Evaluation of the expanded Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program . ORD is evaluating whether the program expansions in selected States increased use of preventive services for children, including dental, vision, and well-baby care. ORD will also evaluate whether the expansions improved the health of young children as they developed. This research uses the SMRF database.

Injuries among Medicaid-eligible children. ORD is determining the incidence and costs of injuries in Medicaid-eligible children. Using the SMRF database, ORD is exploring the relationship between injuries and use of health services. ORD is using other national databases to evaluate other risk factors for childhood injuries among low-income children.

The rural poor. Using the SMRF database, ORD is examining important features of the health care delivery system for rural children, ages 18 and under. ORD will compare the provision of health services to the rural poor with the provision of such services to the urban poor.

Barriers to care for poor children. Using data from the NMIHS, ORD is determining the major barriers to care for Medicaid-insured children compared with privately-insured and uninsured children.

The AIDS population. Using the SMRF database, ORD is examining use and costs of treatment for Medicaid-eligible AIDS patients. For example, use of prescription drugs is being evaluated to determine whether Medicaid-eligible AIDS patients are receiving state-of-the-art pharmaceutical care.

Clinical conditions among Medicare- and Medicaid-eligible elderly. Using the SMRF database, ORD is evaluating the use of certain drugs prescribed for several prevalent diseases. ORD will examine uses for and costs of anticoagulant drugs, which are used to prevent and treat pulmonary emboli, deep vein thrombosis, atrial fibrillation, and acute myocardial infarction.

Health status of poor children. Using the NHANES III data, ORD is comparing parameters of health, including nutritional status, lead levels, and growth, among Medicaid-insured, privately insured, and uninsured children.

Quality of care. ORD is analyzing the results of HCFA's evaluation of the quality of care provided to children with asthma and to women hospitalized for complicated pregnancy or hysterectomy. This is a major research effort that includes detailed data collection on individual hospitalizations.

ORD Research Fact Sheet

Social Health Maintenance Organization Demonstrations

Second Generation Social Health Maintenance Organization (SHMO)

The SHMO offers Medicare beneficiaries the opportunity to receive a wide range of services to meet both acute and long term care needs. The SHMO demonstration includes several unique organizational and financing features, such as a fully integrated structure to provide a range of services to enrollees, a coordinated case management system, an enrollment of a cross section of the elderly population including the functionally impaired and the well elderly, and a financing methodology comprised of prepaid capitation by pooled funds from Medicare, Medicaid, and member premiums.

SHMO I sites have been operational since 1985 and include Medicare Plus II, sponsored by Kaiser Permanente Northwest, Portland, Oregon; SCAN Health Plan, Long Beach California; and Elderplan, Inc., Brooklyn, New York.

The purpose of the second generation demonstration is to refine the targeting and financing methodologies and benefit design of a SHMO. In addition, the projects will provide an opportunity to test more geriatrically oriented models of care, as well as to test expansion to special populations, such as beneficiaries living in rural settings and beneficiaries who are dually entitled to Medicare and Medicaid.

In January 1995 HCFA selected six demonstration sites:

- CAC-United HealthCare Plans of Florida, Coral Gables, Florida
- Contra Costa Health Plan, Martinez, California
- Fallon Community Health Plan, Worcester, Massachusetts
- Health Plan of Nevada, Inc., Las Vegas, Nevada
- Richland Memorial Hospital, Columbia, South Carolina
- Rocky Mountain HMO, Grand Junction, Colorado

Approximately 85,000 Medicare beneficiaries are expected to participate in the SHMO II demonstration.

ESRD Managed Care

ORD is also conducting a demonstration to test whether (1) ESRD beneficiaries should be given access to health maintenance organizations during open enrollment (at present, ESRD beneficiaries cannot enroll in an HMO, but may remain in HMOs if they develop ESRD while already enrolled), (2) the statewide capitation rate should be adjusted (the current ESRD capitation rate is unadjusted), and (3) managed care improves patient outcomes. Under this demonstration, the participating SHMOs will provide integrated acute- and chronic-care management for ESRD beneficiaries and will receive a capitation rate that is 100 percent of the AAPCC. Additional, non-Medicare-covered benefits will be offered by the provider to justify the additional 5 percent of the AAPCC.

In addition to adjustments in the current payment method, a risk adjustment method will be used in which rates will be paid according to (1) treatment status: maintenance dialysis, transplant episode, or functioning graft; and (2) whether diabetes was the cause of renal failure. Rates may be further adjusted for urban/rural residence.

Applicant organizations are likely to be coalitions and consortia, and the component which is to receive the capitation payment from HCFA must satisfy State requirements for bearing risk. A single application may be for a multi-site demonstration, if site-specific detail is provided in regard to service integration.

ORD Research Fact Sheet

Monitoring and Evaluation for the Consumer Information Program

The Consumer Information Program (CIP) has the goal of helping Medicare and Medicaid beneficiaries stay healthy by informing their choices about health care. Medicare and Medicaid data on the use of services and patterns of care are the primary sources of information. ORD plays a critical leadership role in the use of Medicare and Medicaid administrative data to identify campaign topics, to define special problem groups and areas, to monitor State and national trends, to establish consistent analytical methods, and to evaluate specific interventions.

Identification of Topics

ORD researchers participated actively in the development of the CIP and helped to determine its first program activities. ORD analyses showing poor use of influenza immunizations and screening mammograms led to the choice of these two preventive services as the first and second consumer information campaigns of the CIP.

Definition of Special Problem Groups and Areas for Contractor Action

Analyses of administrative data for influenza, mammography, and pneumococcal immunization showed that the entire Medicare population receives these services at much lower rates than the goals set for the Year 2000 by the Department of Health and Human Services. ORD analyses also uncovered particularly low utilization among blacks and the oldest elderly. As a result, HCFA's partnership with Historically Black Colleges and Universities will direct its early efforts at correcting the racial differences in the use of these services. Peer Review Organizations, carriers, and public health entities are also focusing on minorities, as well as those counties found to have particularly low use of preventive services.

Monitor State and National Trends

ORD data products are key components in the influenza and mammography campaign initiatives. State and National rates are developed each year to monitor the progress of the Consumer Information Program. Press conferences and media kits include ORD maps of utilization for the nation overall, as well as for Caucasians and African Americans. Compendia of county level utilization figures reach a wide audience of State and county public health organizations.

Furthering HCFA Data Quality

As more individuals make use of HCFA administrative data, ORD has assumed leadership in promoting the appropriate and consistent use of claims-based data. ORD directs the preparation of master data sets for use by a variety of internal and external partners, including HCFA regional offices, the Association of Medical Peer Review Associations and its member peer review organizations, and the Centers for Disease Control and Prevention. ORD also conducts and assists special studies to estimate use of services outside of fee-for-service Medicare and Medicaid, such as managed care settings and free public health clinics.

Evaluation of Specific Interventions

Data prepared by ORD are used to evaluate the impact of local initiatives by comparing use before and after intervention. Data are also used to elucidate Medicare billing difficulties by public health departments and bring them to resolution.

Activities in Progress

Analyses of influenza immunizations and mammography are done on an annual basis, with similar data development planned for pneumococcal vaccination and pap smears. Also in progress are analyses of treatment patterns for elderly women with early stage breast cancer.

ORD Research Fact Sheet

HCFA On-Line Research Initiative

Background

HCFA On-Line is a comprehensive communications strategy designed to enhance interaction among HCFA, providers, States, and beneficiaries. This plan will coordinate and integrate the agency's current communication activities to ensure that they serve our broad informational goals efficiently and cost-effectively.

A major objective of HCFA On-Line is to study systematically the information needs of the agency's various constituent groups to improve outreach activities related to HCFA programs and improving the health status of beneficiaries. One On-Line activity is the development of a single toll-free telephone number so that the public can easily make one call to obtain information on a wide range of topics. In addition, a variety of other communication technologies are being considered as part of the overall communication system (e.g., cable television programming, use of Federal service kiosks). The ultimate result of the On-Line communication strategy will be improved access to health care and program information as well as increased user awareness and satisfaction.

Research Initiative

As part of the On-Line effort, ORD is implementing a research initiative that includes market research, studies to monitor and evaluate On-Line performance, and research on innovations in communication.

Market Research

Central to the HCFA On-Line effort is listening to the users of information to ensure that the design of the On-Line communication strategy responds to their needs. Our public information users include beneficiaries, provider groups, managed care organizations, State Medicaid agencies, and others who participate in HCFA programs. For each group ORD needs to answer two questions to help guide the development of HCFA On-Line:

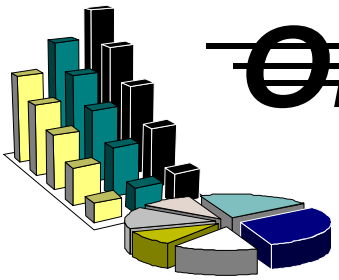
- What information do you need from HCFA?
- How can ORD best get that information to you?

Monitoring and evaluating system performance

ORD will develop and implement a plan for monitoring and evaluating HCFA On-Line systems. It will include the creation of performance indicators that will be meaningful to program managers as well as measures that can be readily incorporated into On-Line reporting systems.

Research on Innovations

ORD will test market new information materials or communication technologies, which will provide information on the public's receptivity to their use. The test marketing also will help determine whether there is sufficient interest and need for HCFA to consider further adoption of these communications innovations.



ORD Functions

ORD Functional Organization

The Office of Research and Demonstrations (ORD) has 180 employees and comprises two staff functions and four offices, as described below. Its research and demonstration budget for FY 1995 (including appropriations for the Rural Health Care Transition Grants program and the Essential Access Community Hospital/Rural Primary Care Hospital program) was almost $65,000,000. In FY 1996, ORD oversees approximately 800 grants, cooperative agreements, contracts and intramural studies. ORD has the statutory authority to experiment with payment alternatives (conduct demonstrations) and to waive applicable laws and regulations for demonstration participants. In addition to general authorities, ORD is often given specific authorities tied to individual, Congressionally-mandated demonstrations.

Office of State Health Reform Demonstrations

OSHRD is responsible for managing the Health Care Financing Administration's (HCFA) Medicare and Medicaid demonstration waiver authorities, including the Federal review, approval, and oversight of State health reform waivers. These waivers generally redesign major sections of a State's Medicaid program. In partnership with other HCFA and Department components, OSHRD directs the Department's response to all aspects of the States' proposals.

Office of Payment and Delivery Research and Demonstrations

OPDRD directs two major sets of activities: the development of more efficient and effective health care delivery systems; and the development, refinement, and testing of payment methods. OPDRD's **Division of Delivery Systems and Financing** conducts research and demonstrations related to managed care and other delivery systems, including the development of infrastructure in rural and other underserved areas. DDSF also develops and tests new payment systems associated with delivery and systems reform. OPDRD's **Division of Payment Systems** is responsible for research and demonstrations related to the development, refinement, and testing of payment policy for hospitals, physicians, skilled nursing facilities, and other providers.

Office of Beneficiary and Program Research and Demonstrations

OBPRD directs research on the Medicare and Medicaid programs and their beneficiary populations. Its **Division of Health Information and Outcomes** focuses on issues such as health status and outcomes, service use, access to care, expenditures, and quality of care. DHIO also conducts research on maternal and child health; specific conditions such as end-stage renal disease and AIDS; and consumer decision-making and beneficiary satisfaction. OBPRD's **Division of Aging and Disability** directs research and demonstrations related to eligibility, coverage, access, and the quality of long-term care services.

Office of Research and Demonstrations Support

ORDS's **Division of Demonstration Support** carries out fiscal intermediary and carrier activities to support the implementation and operation of demonstrations. ORDS's **Division of Data Systems Resources** is responsible for: developing and maintaining a variety of data programs to monitor and evaluate trends in

health care; designing and developing a variety of analytic data bases; and coordinating ORD's participation in computer-based systems.

Financial, Administrative and Procurement Staff

FAPS manages ORD's personnel, budget, administrative, and procurement activities. FAPS also manages ORD's Freedom of Information and Privacy Act activities.

Dissemination Staff

DS manages ORD's dissemination, publications, and inquiries activities. This includes producing and distributing the *Health Care Financing Review*, *Research and Demonstrations Status Report*, and ORD's Reports to Congress. DS serves as ORD's legislative and public affairs liaison. DS also oversees ORD Internet activities and represents ORD on various HCFA-wide Internet workgroups and committees.